DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295043	A. BUILDING _____ B. WING _____	06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	3101 PLUMAS RENO, NV 89509

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on June 4, 2007 to June 8, 2007. The census at the time of the survey was 178. The sample size was 32 including three closed records. There were two complaints investigated during the survey. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state of local laws. Complaint #NV00015161 alleged that the facility failed to provide the necessary services to a resident. The complaint was unsubstantiated. Complaint #NV00013865 alleged that the facility failed to provide quality care to a resident. The complaint was unsubstantiated. The following regulatory deficiencies were identified:	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and	F 241		

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BUREAU OF LICENSURE AND CERTIFICATION
CARSON CITY, NEVADA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Pagale | TITLE: Administrator | (X6) DATE: 6/26/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 interview, it was determined that the facility failed to groom residents in a manner to maintain or enhance resident dignity for 3 of 32 residents. (Residents #30, #31, and #32) Findings include: On 6/5/07 at 8:30 AM, Residents #30, #31, and #32 were observed in the Wellington dining room. It was observed that the three female residents had very long white chin hair. On 6/6/07 at 10:30 AM, Residents #30, #31, and #32 were observed in the Wellington dining room. It was observed that the three female residents had very long white chin hair. At that time, the Director of Staff Development (Employee #4) was interviewed regarding these residents. She stated that she knew two of the residents were resistant to care. On 6/7/07 at 8:30 AM, Residents #30, #31, and #32 were observed in the Wellington dining room. It was observed that the three female residents had very long white chin hair. On 6/7/07 at 9:10 AM, an interview was conducted with the Assistant Director of Nursing (Employee #3). She stated that Resident #30 refused to have her chin hair shaved. She stated that a family member had tried to use a hair cream on her and the resident refused to have that done. She stated that she was going to assist with the AM care today and attempt to get Resident #30 shaved. On 6/7/07 at 10:30 AM, an interview was conducted with a certified nursing assistant (Employee #12). When asked about shaving	F 241	F 241 The center does and will continue to provide grooming to residents in a manner to maintain or enhance resident dignity. • Chin hair was removed for residents #30, #31, and # 32 during survey. Care plans for the residents have been updated to include functional ability with grooming, resistant with hair removal and approaches when the resident is resistant facial hair removal. • All residents with impaired ability to perform self care have the potential to be affected. Care plans will be reviewed for these residents to ensure functional ability with grooming is included in the residents plan of care. • Nursing staff will be inserviced on addressing functional ability and assistance with grooming based on the care plan. The inservice will include approaches to utilize when a resident is resistant to grooming. The plan of care will be reviewed by the IDT team upon admission and during quarterly care conference meetings and change in condition. • Grooming of residents will be monitored during daily rounds by the Director of Nursing and Nurse Managers with followup to findings. Problems identified will be addressed at the monthly QAA meeting for further recommendations.	6/11/07 7/20/07 7/20/07 7/20/07

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F 241	Continued From page 2 female residents she stated that "nine times out of ten when asked, the residents will refuse to let us shave them. Then finally they will let us shave them." On 6/7/07 the medical records of Residents #30 and #31 were reviewed. Resident #30: The resident was admitted to the facility on 3/9/06 with a re-admission date 11/1/06, with the following diagnoses: gait abnormality, circulatory disease, falls, senile dementia, symbolic dysfunction, essential hypertension, transient cerebral attack, and diabetes mellitus. The care plan for Resident #30 was reviewed. The care plan for impaired ability to perform activities of daily living (ADL) and self-care addressed ADL transfers, but did not address grooming. Resident #31: the resident was admitted to the facility on 9/14/06, with the following diagnoses: acute myocardial infarction, symbolic dysfunction, debility, syncope, and white blood cell disease. The care plan of Resident #31 was reviewed. The care plan for impaired ability to perform ADL's and self care addressed ADL status and functional activity tolerance. The approach indicated "encourage resident to participate in self care activities as much as possible." Frequency was listed as every day, and designated responsible discipline was listed as "all staff." On 6/8/07 at 8:30 AM, Residents #30, #31, and #32 were observed to have no chin hair.	F 241	• The Director of Nursing is responsible for compliance.	
F 246	483.15(e)(1) ACCOMODATION OF NEEDS	F 246		

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F 246 SS=D	Continued From page 3 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, it was determined that the facility failed to accommodate the needs of residents during mealtime for 3 of 32 residents. (Residents #25, #6, and #10) Findings include: Resident #25: The resident was admitted to the facility on 4/9/07, with diagnoses including cerebrovascular disease, osteoporosis, hypertension, degenerative joint disease, urinary incontinence and aortic valve stenosis. She was 96 years old and receiving hospice services. She was receiving a regular diet with thin liquids. A record review was done on 6/4/07. The records revealed that Resident #25's minimum data set (MDS) dated 4/26/07, indicated her cognitive skills for decision making were moderately impaired and both her long and short term memories were impaired. The MDS indicated she required extensive assistance with feeding. The nutritional risk assessment form dated 4/26/07, also indicated the resident required "extensive assist with one person assist for meals."	F 246	F 246 The facility does and will continue to accommodate the needs of residents during mealtime. • Resident #25, 6 & 10 will be assisted with meal service as indicated by their individual plan of care. Staff assistance, cueing, tray prep and supervision will be provided as indicated by the plan of care. • The Nurse Managers will audit residents ADL sheets for level of assistance required with eating. Residents identified as requiring assistance with meals will be observed to ensure assistance is provided as needed. • Nursing staff will be inserviced on assisting the residents during meals according to their plan of care. A dining room monitor has been assigned to the dining rooms and rooms of residents that prefer to eat in their rooms. It is the responsibility of the nursing staff to endure that the resident is assisted during meals, including providing verbal cues, food cut into bite size pieces, and with drinks and condiments opened. The dining room monitor will address and report findings identified during meal observations.	6/11/07 7/20/07 7/20/07

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F 246	Continued From page 4 On 6/4/07 at approximately 12:40 PM, Resident #25 was observed at mealtime in the main dining room. She was sitting at a table with two other residents. Although the staff placed the meal tray and fluids on the table for the resident, no physical or verbal assistance was provided to the resident during the meal. The resident attempted to grasp a fluid filled glass, but was unable to reach it. She quietly stated "I can't reach the glass" but staff did not respond and continued to assist other residents. Resident #25 attempted to eat the salad from her tray, but the lettuce repeatedly fell from her fork before she could get it to her mouth. She had difficulty reaching her dessert but was eventually able to grasp the bowl. She had difficulty balancing the jello like substance on her spoon and repeatedly dropped it before she could get it to her mouth. She said "I can't do it." Staff did not observe the resident's difficulty eating. Resident #25 was interviewed on 6/4/07 during the lunch meal. She stated she was hungry and wanted to eat the dessert. Staff were requested to assist the resident with her desert at approximately 1:07 PM. She had eaten only a spoonful of the main entree and was unable to eat dessert. On 6/5/07, a licensed practical nurse (Employee #2) was interviewed. She indicated that Resident #25 required verbal cues and physical assistance to eat. She was not aware of the resident's difficulty eating lunch on 6/4/07. On 6/5/07, the director of nurses (DON) was interviewed. She reported that Resident #25 required monitoring during the meal and often	F 246	• The facility Nutritionist reviews the results of the dining room observations during QAA for compliance. Additional training will be provided for any trends identified. • The Director of Nursing is responsible for compliance	7/24/07

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F 246	Continued From page 5 needed cueing and physical assistance to eat. She confirmed that the resident should be assisted as needed whenever she had the desire to eat. Resident #6: The resident was originally admitted to the facility on 9/1/06, with diagnoses including fractured femoral neck, status post open reduction and internal fixation, atrial fibrillation, hypertension, debility, pain and dementia with agitation. She was 88 years old and was ordered a mechanical soft/enhanced diet. She had moderate cognitive impairment. Resident #6's record was reviewed on 6/4/07. The record revealed she had experienced weight loss was placed on Megace, an appetite stimulant, for the second time. The resident's minimum data set (MDS) dated 4/19/07, indicated she required extensive assistance for eating. Her current care plan indicated she needed encouragement and cues with meals. On 6/4/07 at approximately 12:40 PM, Resident #6 was observed in the main dining room. She was sitting at a table with two other residents. A lunch tray was placed in front of her and staff assisted her by removing the tray lid and setting up her fluids. She did not begin to eat her meal after the tray was set up for her. She did not receive verbal cues or physical assistance to eat her meal. Staff did not ask her why she was not eating or offer an alternative meal. On 6/4/07 at 1:07 PM, Resident #6 was asked why she was not eating her meal. She stated she was going to eat her meal but she never began eating. Her tray remained uneaten until approximately 1:10 PM when she left the dining	F 246		

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F 246	Continued From page 6 room. On 6/5/07, an LPN (Employee #2) was interviewed. She stated that Resident #6 was to receive verbal cues and physical assist when she needed it. The director of nurses was also interviewed on 6/5/07 and indicated the resident required monitoring and assistance for meals. Resident #10: The resident was admitted to the facility on 5/25/07, with the following diagnoses: pneumonia, weight loss, malaise and fatigue, hypo-osmolality, protein-calorie malnourishment, and chronic airway obstruction. On 5/26/07, her weight was 97.1 pounds. On 6/2/07 her weight was 95.4 pounds. On 6/7/07, Resident #10 was observed to be lying in bed with the head of the bed elevated 45 degrees. Her breakfast tray was on the over the bed table. There was a slice of French toast that was not buttered or with syrup, and it was not cut into pieces. The drinks on the tray were unopened. The resident was asked if she was going to eat anything, and she replied that she was trying. On 6/7/07 at 8:45 AM, an interview was conducted with the medication nurse (Employee #13) . When asked about Resident #10's intake and the tube feeding, she stated that if the resident ate 50% of her meal she would not receive the scheduled tube feeding. When asked if Resident #10 could set up her own tray, Employee #13 went into Resident # 10's room, sat her up in bed and prepared her tray. Employee #13 assisted Resident #10 to eat a couple of bites of her French toast.	F 246		

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F 246	Continued From page 7 On 6/7/07 at 09:00 AM, an interview was conducted with a licensed practical nurse (Employee #14). When asked what was the routine for setting up Resident #10's meal trays, she stated that the certified nursing assistant (CNA) would set the resident up after passing her tray. Employee #14 stated that when she asked the CNA about Resident #10's breakfast tray the CNA stated that she had forgotten to go back and sit Resident #10 up in bed and prepare her breakfast tray.	F 246		
F 325 SS=D	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to ensure that 1 of 32 residents maintained acceptable weight parameters and avoided significant weight loss. (Resident #2) Findings include: Resident #2: The resident was admitted to the facility on 4/6/07 with diagnoses including hip fracture, anemia, osteoporosis, and senile dementia. The resident weighed 94 pounds on admission which was below her ideal body weight of 100-110 lbs. The nutrition risk assessment	F 325		

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F 325	Continued From page 8 indicated the resident was 94% of her ideal body weight and a body mass index (BMI) of 18.5. Admission labs revealed an albumin of 2.9. normal range listed as 3.2-5.4. The resident was initially placed on a pureed diet, which she refused to consume. The resident required extensive assistance in eating. There was no mention of edema on the admission nursing assessment or on the physician progress notes. On 4/6/07 physician orders indicated the resident was on the hydration program of 90 cubic centimeters (CC) of fluid every two hours while awake due to poor fluid intake. The nutritional progress notes of 4/27/07, indicated a 9 pound weight loss and noted that it was the result of inconsistent poor intake. The average meal intake was listed at 60%. The albumin level was unchanged at 2.9. The diet order was changed to mechanical soft on 5/1/07, with house shakes twice a day between meals. The dietary change of status report of 5/7/07 indicated a plan to get the resident's weight up and maintain above 90 pounds. From 4/6/07 to 5/31/07, the resident experienced a weight loss of 12 lbs. On 5/31/07, the resident weighed 82 lbs. Discussion with the dieticians (Employees #5 and #6) on 6/7/07, revealed that they were aware of the significant weight loss, and that the resident was to be reevaluated the following week. On 6/7/08, the dietician (Employee #5) initiated action to add supplements during medication pass to the residents diet based on the resident's weight of 83 pounds on 6/6/07. Based on the resident's continued weight loss	F 325	F 325 The facility will ensure that residents maintain acceptable weight parameters and avoid significant weight loss. • Resident # 2 was assessed by the RD and VHC 2 ounces was initiated and labs obtained • Residents with weight loss have the potential to be affected. Residents current weights will be reviewed by the Registered Dietitian or Nutritionist to identify significant weight loss for further followup and change in approaches to the plan of care as needed. • The Registered Dietitians have been inserviced in the nutritional management process. The Registered Dietitians and/or Nutritionist will monitor new admits weekly for four weeks. Residents will be weighed at least monthly. Weekly weights will continue as needed. Significant weight loss will be reviewed daily with the IDT team daily during morning meeting with monitoring for timely follow up. The Administrator will document monitoring for RAP completion, significant change MDS, dietary evaluation, referrals, care plan interventions and status update.	6/11/07 7/20/07 7/20/07

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F 325	Continued From page 9 and the significant loss of 4 pounds in one week from 5/9/07 to 5/17/07, the facility failed to take action to prevent further weight loss until 6/7/07.	F 325	• The Registered Dietitians and/or Nutritionist will present findings during the monthly QAA meeting for further recommendations as needed.	7/20/07
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation and record review it was determined that the facility failed to maintain a medication error rate of less than five percent. Findings Include: On 6/5/07, a medication pass observation was made on two different hallways with two different facility nurses. Four errors were noted out of 47 opportunities for errors. One of these errors was a significant medication error - See Tag F 333. The medication pass error rate was eight and one-half percent. The medication errors were noted as follows: 1. Resident #17: On 6/5/07, at approximately 8:30 AM, during the medication pass it was observed that Resident #17 was administered Buffered Aspirin 325 mg. Review of the physician's orders, with an order date of 5/4/07, revealed that the resident had an order for Enteric Coated Aspirin 325 mg. The entry had been crossed out with the word error after it. A review of the medication administration record (MAR) revealed that the Aspirin was never	F 332		

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F 332	Continued From page 10 discontinued from the MAR and it was documented that Resident #17 received the Aspirin from 5/5/07 through 6/5/07, except on 5/18/07. In addition, the original order was for Enteric Coated Aspirin not Buffered Aspirin. The facility's consulting pharmacist was interviewed via the telephone on 6/7/07, at 1:10 PM. He stated that Buffered Aspirin and Enteric Coated Aspirin are two different formularies and that one can not be substituted for the other. Cross reference Tag 333 (Significant Medication Error) 2. Resident #18: The nurse was observed to administer Reglan 5 mg to the resident at 8:50 AM on 6/5/07, after breakfast. Review of the physician's orders revealed an order for Reglan 5 mg twice a day for five days for abdominal discomfort. Review of The Geriatric Dosage Handbook, 12th Edition, revealed that Reglan was supposed to be administered 30 minutes before meals or food. 3. Resident #18 also had Paxil CR 25 mg ordered once a day. The nurse was observed to crushed the Paxil CR along with the resident's other medications. She held on to the medication cup with the crushed Paxil CR preparing to administer it to the resident. The nurse was stopped and asked about the Paxil CR before she administered it to the resident. The Geriatric Dosage Handbook, 12th Edition, revealed that Paxil CR was not supposed to be crushed. The director of nursing called a pharmacist on 6/5/07, at 3:00 PM. The pharmacist confirmed that Paxil CR was not to be crushed. 4. Resident #19: The nurse was observed to	F 332	F 332 The facility will maintain a medication error rate of less than five percent. • The Enteric Coated Aspirin was discontinued from the MAR (Medication Administration Record) for Resident #17 as ordered. It was noted on the MAR for Resident #18 that Reglan is to be administered 30 minutes before meals. It was noted on the MAR for Resident #18 that Paxil CR should not be crushed. It was noted on the MAR for Resident #19 that Ibuprofen should be administered with food. • The Nurse Managers will audit the Medication Administration Records with follow-up to any findings related to proper medication administration. • Licensed nurses will be inserviced on proper administration of medications, including times that medications should be administered, correct medications and medications that should not be crushed. A listing of medications that should not be crushed will be placed in the MAR binder. In addition, they will be inserviced on proper transcription when a medication is discontinued and medication error reporting.	6/11/07 7/24/07 7/24/07

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F 332	Continued From page 11 administer Ibuprofen 400 milligrams at 7:55 AM on 6/5/07, before breakfast and without food. Review of the physician's orders revealed an order for Ibuprofen 400 milligrams by mouth three times daily with food.	F 332	• The Pharmacy Consultant will conduct monthly medication reviews with reports of findings provided to the Director of Nursing for follow-up. Identified trends will be reported to the QAA committee for further recommendations.	7/20/07
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to prevent a significant medication error for 1 of 32 residents. (Resident #17) Findings include: Resident #17: The resident was admitted on 5/4/07. The resident's diagnoses included coronary artery disease, hypertension, and prostate cancer. Review of Resident #17's admission history and physical revealed that the resident had a gastrointestinal bleed in May of 2006 secondary to excess Aspirin. Review of the physician's order, with an order date of 5/4/07, revealed an order for Enteric Coated Aspirin 325 mg which had been crossed out with the word error after it. On 6/4/07, at 10:55 AM, the director of nursing interviewed the nurse that had crossed out the order for the Aspirin. The nurse stated that the physician discontinued the Aspirin on 5/4/07 because of the resident's risk for gastrointestinal bleeding.	F 333	F 333 The facility will ensure that residents are free of any significant medication errors. • The Enteric Coated aspirin was discontinued from the MAR for Resident #17 as ordered. • The Nurse Managers will audit the Medication Administration Record with current physician orders to identify discrepancies in transcription • The nurse responsible for discontinuation of the medication will be re-educated with counseling. Licensed nurses will be inserviced on accurate transcription when an order has been discontinued. In addition, licensed nurses will receive education on Medication Error reporting.	6/11/07 7/12/07 7/20/07

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F 333	Continued From page 12 On 6/5/07, at approximately 8:30 AM, during the medication pass it was observed that Resident #17 was administered Buffered Aspirin 325 mg. A review of the medication administration record (MAR) revealed that the Aspirin was never discontinued from the MAR. It was documented that the resident received the Aspirin from 5/5/07 through 6/5/07, except on 5/18/07. In addition, the original order was for Enteric Coated Aspirin not Buffered Aspirin. The facility's consulting pharmacist was interviewed via the telephone on 6/7/07, at 1:10 PM. He stated that Buffered Aspirin and Enteric Coated Aspirin are two different formularies and that one can not be substituted for the other.	F 333	• The Pharmacy Consultant will conduct monthly medication reviews with reports of transcription discrepancies provided to the Director of Nursing for follow-up. Identified trends will be reported to the QAA committee for further recommendations.	7/2/07
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to ensure that one cook properly observed safe food handling practice during meal service. Findings include: During the tray line service of the noon meal on 6/4/07, the cook serving at the tray line was observed to remove the aluminum foil from a pan in the steam table with gloved hands and to dispose of the foil in the trash can. To dispose the foil into the trash can she removed the lid of	F 371	F 371 The facility does and will continue to store, prepare, distribute and serve food under sanitary conditions. • The cook has been inserviced on glove use and correct handwashing techniques. • All residents have the potential to be affected • Dietary staff will be inserviced on glove use and correct handwashing techniques. The Dietary Manager is responsible to ensure that the dietary staff utilize correct handwashing techniques. The Dietary Manager will observe handwashing techniques during food preparation and distribution. • The Registered Dietitian will conduct random weekly observations for proper glove use and handwashing technique with follow-up as needed. Trends will be reported to the Administrator for QAA review.	6/11/07 6/11/07 7/20/07 7/20/07

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F 371	Continued From page 13 the trash can with her gloved hands. The cook then went to the sink, rinsed her gloved hands and returned to the tray line. The cook did not remove her gloves to wash her hands nor did she change gloves after handling the trash can lid.	F 371		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	F 431 The facility will ensure drugs are stored properly and drugs are labeled in accordance with facility policy. • The opened and undated vials of pneumococcal vaccine and multi-dose heparin were discarded. • A visual inspection by the Director of Nursing was completed and all opened and unlabeled vials were discarded. • Licensed nurses will be inserviced on proper labeling and dating when a multi-dose vial is opened. It is the night nurse's responsibility to monitor and document refrigerator temperatures on a daily basis. The night nurse will be re-educated with counseling on completion of the temperature logs. The Director of Nursing or designee will make periodic inspections of the medication carts and medication rooms. • The Director of Nursing or designee will review the binder with the temp logs on a daily basis. Problems identified will result in additional education and counseling by the Director of Nursing.	6/11/07 6/11/07 7/20/07 7/20/07

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F 431	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy and procedure review, it was determined that the facility failed to ensure the proper storage and labeling of drugs in accordance with facility policy. Findings include: On 6/5/07, the medication room on the Wellington unit was observed and the following was noted: 1. The temperature log for the medication refrigerator for the month of May was missing fifteen days of recorded temperatures. 2. Two vials of multi-dose pneumococcal vaccine in the refrigerator were opened and undated. On 6/5/07, the medication cart on the Wellington unit was observed and the following was noted: 1. One vial of multi-dose heparin was in a plastic bag labeled with the resident's name. The vial was opened and undated. On 6/6/07, the facility's policies and procedures for pharmaceutical services was reviewed and revealed: Storing Drugs procedure #10: "Drugs requiring storage in a cool place must be stored in a refrigerator designated for medications only, and maintained between 2 degrees Celsius (35 degrees Fahrenheit) and 8 degrees Celsius (45 degrees Fahrenheit). The medication refrigerator must contain a functional thermometer designed	F 431		

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F 431	Continued From page 15 for use in a refrigerator. The refrigerator temperature should be monitored and logged on a daily basis." Medication Expiration procedure #4: "Multiple dose injectables containing preservatives (including insulin) will expire 30 days after opening. All such containers shall be dispensed with a Date Opened sticker attached." On 6/6/07 at 11:10 AM, an interview was conducted with the director of nursing (Employee #1). When asked about the blanks on the refrigerator temperature log, she stated that it was night shift's responsibility to check the refrigerator temperature, and that it had been missed for those days. When asked about dating multi-dose vials, she stated that they should all have a date opened sticker attached, and the date written on that label. On 6/5/07, at 9:00 AM, the medication room for the Stratford unit was observed to have two cardboard boxes of medications. There was a smaller cardboard box filled with medications in a larger cardboard box filled with medications. The smaller box had a resident's name hand written on it. The larger box had no identification on it and the medications inside were not labeled with resident names. At 9:50 AM, the nurse supervisor for the area that day was shown the boxes. She stated since there were no residents' names on the medication bottles or on the large box she was not aware of who the medications belonged to. A nurse from the unit stated that both boxes belonged to a resident who came in to the facility recently. She stated that the resident had no family to give the medications to. The director of nursing was then	F 431		

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F 431	Continued From page 16 asked about the boxes. She stated that the medications were supposed to be put in plastic zip lock bags and clearly labled with the resident's name.	F 431		
F 442 SS=E	483.65(b)(1) PREVENTING SPREAD OF INFECTION When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. This REQUIREMENT is not met as evidenced by: Based on record review, facility staff interview, and observation, it was determined that the facility failed to provide isolation equipment to prevent the spread of infection in accordance with the facility policies and procedures for 1 random resident and for 2 of 32 residents (Residents #22 and #23) and failed to dispose of used syringes in a manner to prevent the spread of infection. Findings include: On 6/5/07 at 9:45 AM, observation of resident rooms on the 600 hall revealed that one resident room (random resident) had a sign placed on door alerting staff and visitors to check with nurses station before entering room. Upon interview of Employee #9, he stated that the sign was on the door because the resident has clostridium difficile, and was on contact isolation. Employee #8 was also present during interview and stated that if a resident was on contact isolation staff would wear gloves. If there was a possibility that the staff members clothing may become soiled while caring for the resident, then	F 442	F 442 The facility does and will provide isolation equipment to prevent the spread of infection. The facility will dispose of used syringes in a manner to prevent the spread of infection. • Supplies needed to prevent the spread of infection were provided for residents requiring isolation equipment. The sharps container was replaced with a container with a lid. • Infection surveillance tracking will be audited to identify residents with an infectious process and supplies will be provided to prevent the spread of infection.	6/11/07 7/12/07

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F 442	Continued From page 17 staff may need to wear a gown. When asked where the protective clothing was stored, Employee #8 stated that the gloves were kept in the room. When asked where they would get gowns if needed, she stated "they are in the clean storage room down the hall, they are normally kept in the room in a cart or chest." No cart or storage chest was observed in or outside of the resident's room. Employee #2 was interviewed on 6/5/07 at 11:00 AM. She stated that she was aware that the resident had clostridium difficile and was placed on contact isolation. She also stated that gloves were available in all resident rooms. When asked about the potential soiling of staff clothing, she stated that the staff would wear gowns that were found in the cart or chest just inside/outside of the resident's room. When shown that the cart/chest was absent, she stated, "The CNA's can get gowns down the hall if they need them." The clean storage room where gowns were found to be located was noted to be across the hall and down three doors, with a locked access door. When asked about the process by which the isolation cart would get to the patient room, she stated that the nurse was responsible for contacting ancillary services, then ancillary services would place the sign and the cart in the patient room. On 6/5/07 at 12:40 PM, Employee #11 (ancillary services) was interviewed. He stated that he had never been called to place signs or carts to residents rooms. He stated that he believed that housekeeping provided these items. On 6/5/07 at 1:10 PM, Employee #10 was interviewed and stated that "housekeeping is	F 442	• When a resident is identified with an infection, the unit nurse will update the monthly infection surveillance log. The unit nurse will be responsible to notify the ancillary service dept when personal protective equipment is required based on standard or transmission based precautions. The nurse will ensure the equipment is available for staff use. Mobile carts with Personal Protective Equipment and signage will be available for immediate use. These mobile carts will be maintained in the resident's room for accessibility for staff. Staff will be inserviced on the use of the surveillance log, precautions and personal protective equipment availability. The inservice will also include replacement requirements for sharps containers. • The Director of Nursing or designee is responsible to monitor compliance during daily rounds, including staff interview and observation of availability of Personal Protective Equipment based on the Surveillance tracking.	7/20/07 7/20/07

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F 442	Continued From page 18 responsible for providing red bags for infectious waste, and cleaning the room in a way that prevents cross-contamination." She also produced a written policy and procedure that specified the same. She then stated that "ancillary services is responsible for providing the equipment for isolation rooms." On 6/5/07 at 1:30 PM, Employee #1 was interviewed and stated that nurse taking care of resident was responsible for notifying ancillary services to bring the necessary equipment including signs and cart/chest. She also stated that there should be a cart/chest available just inside or outside of the resident's room. She stated, "I will take care of the problem within 20 minutes." On 6/5/07 at 1:40 PM, the resident's room was observed with an isolation chest just outside of resident room. On 6/5/07 at 11:00 AM, Employee #2 was interviewed. When asked if there were any other residents that were in isolation precautions for infections, she stated "No, there is one resident that is being transferred over from another unit with an infection, but there are no other residents over here with infections." On 6/6/07 at 8:20 AM, on the 600 hall, two additional rooms were observed with signs on the door instructing staff and visitors to check with the nurses' station before entering the resident rooms. There were no carts/chests observed inside or outside of these rooms. On 6/6/07 at 10:15 AM, Employee # 2 was interviewed. When asked why signs were found on the residents doors, she stated, "one of them has clostridium difficile (Resident #23) and the	F 442		

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F 442	Continued From page 19 other has a urinary tract infection with methicillin resistant staphylcoccus aureus in his urine (Resident #22)." When asked if she was aware of these on 6/5/07, she stated yes, but must have misunderstood my question on that day. She stated that she was unaware that no isolation equipment was available for the rooms. When asked what type of isolation precautions would be implemented for Resident #22 with methicillin resistant staphylcoccus aureus infection, she stated, "I haven't gotten to that yet." Upon review of the residents medical record, it was revealed that the resident had been admitted on 5/8/07 with the infection having been identified at the previous facility. On 6/6/07 at 10:35 AM, Employee #1 was interviewed. She stated that apparently somebody just did not follow through. "Everyone should be aware of the residents being in isolation, and the equipment should be available near the residents' rooms." On 6/6/07 at 09:35 AM, the medication room on the Wellington unit was observed. A sharps container without a lid was observed sitting near the sink. A syringe with a needle attached was observed in the sharps container without a lid. On 6/6/07 at 09:36 AM, an interview was conducted with the medication nurse (employee #15). When asked about the sharps container without a lid, she stated that it should have a lid. She looked in the medication room and was unable to find a lid for the sharps container.	F 442		